### APPENDIX A: CALCULATION OF BENEFITS<sup>1</sup>

#### **INJURIES ON OR AFTER 1-1-2013**

The following methods of calculating incapacity benefits are acceptable for the purpose of Board audits:

#### **Total Incapacity (Section 212)**

Payments for a fraction of a week shall be figured in sevenths (1/7). This calculation includes Saturday and Sunday.

**Example:** Assume Hearing Officer orders employee to be paid for 16 days.

Weekly Compensation Rate x 2 2/7 = Weekly Compensation Rate x 16/7 = Amount Due

#### **Partial Incapacity (Section 213)**

The weekly compensation is equal to 2/3 of the difference, due to the injury, between the employee's average gross weekly wages, earnings or salary before the injury and the average gross weekly wages, earnings or salary that the employee is able to earn after the injury, but not more than the maximum benefit under section 211.

To calculate partial benefits:

- (1) Determine the weekly compensation rate for the employee's pre-injury average weekly wage. Pre-injury average weekly wage  $x = 2 \div 3$ .
- (2) Determine the weekly compensation rate for the employee's post-injury gross weekly wages. Post-injury gross weekly wages  $x = 2 \div 3$ .
- (3) Subtract the post-injury rate from the pre-injury rate. The difference is the partial benefit amount due for the week.

**Example:** Assume January 2013 date of injury, pre-injury average weekly wage of \$400 and employee returns to work part-time, earning \$200 per week.

Wage Rate \$400 \$266.66 \$200 \$133.33 \$133.33 Partial Benefit Amount Due

<sup>&</sup>lt;sup>1</sup> If fringe benefits are involved, they will be included pursuant to Section 102(4)(H).

### APPENDIX B: AWW CALCULATION

Average weekly wages must be calculated in accordance with Section 102(4), of the Maine Workers' Compensation Act of 1992. Furthermore, the applicability of subsections A, B, C and D must be considered in the order that those subsections appear.

The following pages provide examples of typical WCB-2, Wage Statements. Each example contains an "AWW calculation explanation" at the bottom of the page. These "AWW calculation explanations" are designed to offer general guidance for the application of Section 102(4). They are for illustrative purposes only, and do not represent official Board policy.

#### WAGE STATEMENT STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE		6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:				
2. EMPI	LOYER NAME:			8. EMPLOYEE LA	ST NAM	ΛΕ:		9. FIR	ST NAME:		10. M.I.:
	1	Store							Bess	S	
3. EMPI	LOYER MAILING A	DDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER .	AND STR	REET:	ı			
4. INSUF	RER NAME:			12. CITY:			13. STATE	: 14. Z	IP:	15. HOME F	'HONE:
5 INIQUE	RER MAILING ADI	DESS:		16. DATE OF INJU	IDV:	145	7. DESCRIP	TION OF	IN II IDV		
J. IIVSU	KEK WAILING ADI	JREGG.		5/10/	-	''	. DESCRIP	TION OI	INJOKT.		
	ES EMPLOYEE W			YES			LOYEE REC				YES 🗆
IF `		LOYER? YER SHALL SUBMIT A V EACH ADDITIONAL EMF		NO			THAT MAY S; COMPENS				NO 🗆
20 WK	WEEK ENDING	GROSS EARNINGS	WK					10/1/			
1	5/22/10	400.00	19	9/25/10	350.00 WK				1/29/11		225.00
2			20					38			
3	5/29/10	425.00	21	10/2/10			250.00	39	2/5/11		225.00
4	6/5/10	425.00	22	10/9/10		;	325.00	40	2/12/11		350.00
	6/12/10	425.00		10/16/10			200.00		2/19/11		275.00
5	6/19/10	450.00		10/23/10		2	250.00	41	2/26/11		275.00
6	6/26/10	425.00	24	10/30/10		;	300.00	42	3/5/11		250.00
7	7/3/10	500.00	25	11/6/10		2	250.00	43	3/12/11		225.00
8	7/10/10	475.00	26	11/13/10		,	300.00	44	3/19/11		325.00
9	7/17/10	450.00	27	11/20/10		(	325.00	45	3/26/11		350.00
10	7/24/10	450.00	28	11/27/10			500.00	46	4/2/11		400.00
11	7/31/10	450.00	29	12/4/10			450.00	47	4/9/11		400.00
12	8/7/10	490.00	30	12/1/10			425.00	48	4/16/11		350.00
13		Includes advance vacation pay	31					49			
14	8/14/10	800.00	32	12/18/10			455.00	50	4/23/11		325.00
15	8/21/10	0.00	33	12/25/10		(	650.00	51	4/30/11		375.00
	8/28/10	425.00		1/1/11		4	400.00		5/7/11		350.00
16	9/4/10	425.00		1/8/11			300.00	52	5/14/11		400.00
17	9/11/10	350.00	35	1/15/11	250.00 EARNINGS			s 19,0	020.00		
18	9/18/10	325.00	36	1/22/11		2	22. GROSS AVERAGE				

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. Vacation pay for the week ending 8/21/10 appears to have been paid during the week ending 8/14/10 (see documentation above). Therefore, the Total Earnings should be divided by 52 weeks (§102(4)(B)).

# WAGE STATEMENT STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECU	RITY NU	MBER		7. WCB FILE NUMBER:			
2. EMPI	LOYER NAME:		8. EMPLOYEE LA	AST NAM	IE:		9. FIR	ST NAME:		10. M.I.:	
		ployed logger		0. 2 20 . 22 2					Chuc	k	
3. EMPI	LOYER MAILING A	DDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STR	EET:	1			1
4. INSUF	RER NAME:			12. CITY:			13. STATE	: 14. Z	ZIP:	15. HOME	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU		17	. DESCRIP	TION OF	= INJURY:		
				5/11/	/11						
				-1							
	ES EMPLOYEE W R ANOTHER EMP			YES			LOYEE REC				YES
IF `	YES, THE EMPLO	YER SHALL SUBMIT A V EACH ADDITIONAL EMF		NO 🗌			; COMPENS				NO 🗌
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS						10/1/	1		
1	1/8/10	800.00	WK 19	5/14/10		10	250.00				1225.00
2			20					38			
	1/15/10	825.00	21	5/21/10	1350.00				9/24/10	)	1225.00
3	1/22/10	725.00	;	5/28/10	13	325.00		10/1/10	)	1350.00	
4	1/29/10	925.00		6/4/10		12	200.00	40	10/8/10	)	725.00
5	2/5/10	950.00		6/11/10		12	250.00	41	10/15/1	0	275.00
6	2/12/10	925.00	24	6/18/10		13	300.00	42	10/22/1	0	1450.00
7	2/19/10	1500.00		6/25/10		12	250.00	43	10/29/1	0	1450.00
8	2/26/10	1475.00	26	7/2/10		13	300.00	44	11/5/10	)	1450.00
9	3/5/10	0.00	27	7/9/10		13	325.00	45	11/12/1	0	890.00
10	3/12/10	0.00	28	7/16/10			500.00	46	11/19/1		800.00
11	3/19/10	0.00	29 .	7/23/10		5	550.00	47	11/26/1	0	780.00
12	3/26/10	0.00	30	7/30/10			325.00	48	12/3/10		1425.00
13	4/2/10	0.00	31	8/6/10			755.00	49	12/10/1		1425.00
14	4/9/10	0.00	32	8/13/10			650.00	50	12/17/1		1350.00
15	4/16/10	.00	33	8/20/10			100.00	51	12/24/1		650.00
16	4/23/10	0.00	34	8/27/10			700.00	52	12/31/1	0	700.00
17	4/30/10	0.00	35	9/3/10		12	250.00	21. TOTAL 0 EARNINGS \$ 43,750.00			
18	5/7/10	325.00	36	9/10/10		12	250.00		OSS AVERAGE		1.35

AWW calculation explanation: Logging is seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be divided by 52 weeks.

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMP	LOYER NAME:	Store		8. EMPLOYEE LA	AST NAI	ME:	9.	FIRST NAME:	)	10. M.I.:	
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	: 11. ADDRESS-NU	JMBER	AND STREET:	L			l	
4. INSUI	RER NAME:			12. CITY:		13. S	TATE: 1	4. ZIP:	15. HOME I	PHONE:	
5. INSU	IRER MAILING AD	DRESS:		16. DATE OF INJ 5/12/		17. DES	CRIPTION	OF INJURY:			
FO IF ` ST.				YES	В	OES EMPLOYE ENEFITS THAT ORKERS; COM	MAY STO	P WHILE ON		YES  NO	
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS	WK				Wł				
1	5/22/10	200.00	19	9/25/10		150.	00 37	1/29/11	1	325.00	
2	5/29/10	225.00	20	10/2/10		200.	00 38	2/5/11		400.00	
3	6/5/10	400.00	21	10/9/10		425.	00 39	2/15/11	1	225.00	
4	6/12/10	325.00	22	10/16/10		375.	00 40	2/19/11	1	250.00	
5	6/19/10	275.00	23	10/23/10		175.		2/26/11	1	330.00	
6	6/26/10	280.00	24	10/30/10		125.		3/5/11		320.00	
7	7/3/10	400.00	25	11/6/10		155.		3/12/11	1	275.00	
8	7/10/10	475.00	26	11/13/10		145.		3/19/11	1	250.00	
9	7/17/10	425.00	27	11/20/10		275.	00 45	3/26/11	1	200.00	
10	7/24/10	425.00	28	11/27/10		225.	00 46	4/2/11		200.00	
11	7/31/10	340.00	29	12/4/10		250.	00 47	4/9/11		450.00	
12	8/7/10	350.00	30	12/11/10		275.	00 48	4/16/11	1	400.00	
13	8/14/10	230.00	31	12/18/10		300.		4/23/11	1	325.00	
14	8/21/10	320.00	32	12/25/10		350.	00 50	4/30/11	1	350.00	
15	8/28/10	425.00	33	1/1/11		160.	00 51	5/7/11		180.00	
16	9/4/10	400.00	34	1/8/11		140.	00 52	5/14/11	1	220.00	
17	9/11/10	350.00	35	1/15/11		130.	21. TOTAL 30.00 EARNINGS \$ <b>14</b> ,		s 14,	895.00	
18	9/18/10	375.00	36	1/22/11		120.		22. GROSS AVERAGE		7.75	

AWW calculation explanation: This employee's biweekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 5/14/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$14,675.00) should then be divided by 51 weeks (§102(4)(B)).

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMPI	LOYER NAME:	Store		8. EMPLOYEE LA	ST NAMI	E:		9. FIR	ST NAME:  Davie	d	10. M.I.:
3. EMPI	OYER MAILING A	DDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STE	REET:				
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. Z	ZIP:	15. HOME F	'HONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU 6/15/		1	7. DESCRIPT	TIÓN OF	FINJURY:		
FO IF `				YES	BEI	NEFITS	PLOYEE REC THAT MAY S S; COMPENS	STOP W	/HILE ON		YES  NO
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37			
2			20					38			
3			21					39			
4			22					40			
5			23					41			
6			24					42			
7			25					43			
8			26					44			
9			27					45			
10			28					46			
11			29					47			
12			30					48			
13			31					49	5/28/11		50.00
14			32					50	6/4/11		400.00
15			33					51	6/11/11		200.00
16			34					52	6/18/11		150.00
17			35			21. TOTAL EARNINGS \$ <b>800.00</b>			.00		
18			36					22. GROSS AVERAGE WEEKLY WAGE			known

AWW calculation explanation: There are not enough weeks to apply §102(4)(A), and §102(4)(C) cannot be used because this is not seasonal employment. Section 102(4)(B) may not be reasonable or fair in this case, therefore, comparable employees' wages should be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at an AWW that reasonably represents the employee's weekly earning capacity (§102(4)(D)).

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

I. INSURER FILE NUMBER:     2. EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMPI		laatami		8. EMPLOYEE LA	AST NAM	ΛE:		9. FIR	ST NAME:		10. M.I.:
	Г	actory							Bruc	e	
3. EMPI	LOYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER .	AND STR	EET:				
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. Z	IP:	15. HOME	E PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU 7/25/		17	. DESCRIPT	ION OF	F INJURY:		
FO IF `				YES NO	BE	ENEFITS T	LOYEE REC THAT MAY S ; COMPENS	STOP W	/HILE ON		YES   NO
WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	8/7/10	420.00		12/11/10		4	168.00	37	4/16/11		650.00
2	8/14/10	400.00		12/18/10		4	192.00	38	4/23/11		650.00
3	8/21/10	352.00	21	12/18/10 12/25/10			500.00	39	4/30/11		425.00
4	8/28/10	468.00	22	1/1/11		4	188.00	40	5/7/11		455.00
5	9/4/10	500.00	23	1/8/11		5	500.00	41	5/14/11		465.00
6	9/11/10	325.00	24	1/15/11		4	172.00	42	5/21/11		410.00
7	9/18/10	250.00	25	1/22/11		4	168.00	43	5/28/11		465.00
8	9/25/10	600.00	26	1/29/11		3	300.00	44	6/4/11		400.00
9	10/2/10	425.00	27	2/5/11		3	350.00	45	6/11/11		500.00
10	10/9/10	390.00	28	2/12/11		3	375.00	46	6/18/11		352.00
11	10/16/10	350.00	29	2/19/11		5	590.00	47	6/25/11		468.00
12	10/23/10	425.00	30	2/26/11		4	125.00	48	7/2/11		500.00
13	10/30/10	400.00	31	3/5/11		4	100.00	49	7/9/11		325.00
14	11/06/10	600.00	32	3/12/11		3	350.00	50	7/16/11		250.00
15	11/13/10	525.00	33	3/19/11			100.00	51	7/23/11		425.00
16	11/20/10	500.00	34	3/26/11			125.00	52	7/30/11		100.00
17	11/27/10	550.00	35	4/2/11		3	325.00	21. TOT		s 22	2,848.00
18	12/4/10	600.00	36	4/9/11		F	00.00	22. GROSS AVERAGE			46.04

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 7/30/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$22,748.00) should then be divided by 51 weeks (§102(4)(B)).

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECU	RITY NUI	MBER		7. WCB FILE NUMBER:			
2. EMPI		Office		8. EMPLOYEE LA	AST NAMI	E:		9. FIR	ST NAME: Barba	ıra	10. M.I.:
3. EMPI	OYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STRE	EET:				
4. INSUF	RER NAME:			12. CITY:			13. STATE	: 14. Z	IP:	15. HOME F	PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJU 7/26/		17.	DESCRIP	TION OF	FINJURY:	I	
FO IF ` ST				YES D	BEN	NEFITS T	OYEE REC HAT MAY COMPEN	STOP W	HILE ON		YES   NO
20. WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37	4/16/11	ı	450.00
2				12/18/10	2	50.00	38	4/23/11	I	450.00	
3				12/25/10	4	50.00	39	4/30/11	I	450.00	
4				1/1/11		4	50.00	40	5/7/11		450.00
5				1/8/11		4	50.00	41	5/14/11		450.00
6				1/15/11		4	50.00	42	5/21/11		450.00
7				1/22/11		4	50.00	43	5/28/11	1	450.00
8				1/29/11		4	50.00	44	6/4/11		450.00
9				2/5/11		4	50.00	45	6/11/11	ı	450.00
10				2/12/11		4	50.00	46	6/18/11	ı	450.00
11				2/19/11		4	50.00	47	6/25/11	ı	450.00
12				2/26/11		4	50.00	48	7/2/11		450.00
13				3/5/11		4	50.00	49	7/9/11		450.00
14				3/12/11		4	50.00	50	7/16/11	ı	450.00
15				3/19/11		4	50.00	51	7/23/11	ı	450.00
16			34	3/26/11		4	50.00	52	7/30/11	ı	300.00
17				4/2/11			50.00	21. TOTAL  EARNINGS \$ '  22. GROSS AVERAGE			500.00
18			36	4/9/11		4	50.00		JSS AVERAGE FKI Y WAGE		0.00

AWW calculation explanation: It appears that this employee did not work at least 200 full workdays during the preceding year, so §102(4)(A) cannot be used. The week ending 12/18/10 includes the week of hire, and the week ending 7/30/11 includes the date of injury. Both of the aforementioned weeks reduce the AWW, and should therefore be excluded. The remainder (\$13,950.00) should then be divided by 31 weeks (§102(4)(B)).

## WAGE STATEMENT STATE OF MAINE KERS' COMPENSATION BO

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	ER:		6. SOCIAL SECU	RITY NU	JMBER		7. V	VCB FILE NU	JMBER	<b>:</b> :
2. EMP	LOYER NAME:	actory		8. EMPLOYEE LA	AST NAM	ME:		9. FIR	ST NAME:  Brence	la	10. M.I.:
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	R: 11. ADDRESS-NU	JMBER	AND STREI	ET:				<u> </u>
4. INSUI	RER NAME:			12. CITY:		1	3. STATE:	14. Z	IP:	15. H	OME PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJ		17. [	DESCRIPT	TON OF	FINJURY:		
FO IF ST				YES	BE	OES EMPLO ENEFITS TH VORKERS; (	HAT MAY S	STOP W	/HILE ON		YES
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	8/7/10	420.00	19	12/11/10		46	88.00	37	4/16/11		650.00
2	8/14/10	400.00	20	12/18/10		49	92.00	38	4/23/11		650.00
3	8/21/10	0.00	21	12/25/10		50	00.00	39	4/30/11	425.00	
4	8/28/10	468.00	22	1/1/11			0.00	40	5/7/11		455.00
5	9/4/10	500.00	23	1/8/11		50	00.00	41	5/14/11		465.00
6	9/11/10	325.00	24	1/15/11		47	72.00	42	5/21/11		410.00
7	9/18/10	250.00	25	1/22/11		46	88.00	43	5/28/11		465.00
8	9/25/10	600.00	26	1/29/11		30	00.00	44	6/4/11		400.00
9	10/2/10	425.00	27	2/5/11		35	50.00	45	6/11/11		500.00
10	10/9/10	390.00	28	2/12/11		37	75.00	46	6/18/11		352.00
11	10/16/10	350.00	29	2/19/11			0.00	47	6/25/11		468.00
12	10/23/10	425.00	30	2/26/11		42	25.00	48	7/2/11		500.00
13	10/30/10	400.00	31	3/5/11		40	00.00	49	7/9/11		325.00
14	11/06/10	600.00	32	3/12/11		35	50.00	50	7/16/11		0.00
15	11/13/10	525.00	33	3/19/11		40	00.00	51	7/23/11		425.00
16	11/20/10	500.00	34	3/26/11			25.00	52	7/30/11		600.00
17	11/27/10	550.00	35	4/2/11		32	25.00		RNINGS		21,668.00
18	12/4/10	600.00	36	4/9/11		60	00 00		OSS AVERAGE		A51 A2

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. There were no earnings during the weeks ending 8/21/10, 1/1/11, 2/19/11 and 7/16/11, so those weeks should be excluded, and the Total Earnings should be divided by 48 weeks (§102(4)(B)).

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2 EMDI	OVER NAME:			8. EMPLOYEE LA	MAIN TS	IE.	1	0 FIR	ST NAME:		10. M.I.:
Z. LIVII L		mer Camp		O. LIWII LOTEL LA	OT NAM	ı <b>L</b> .		3. I IIV	Carl	l	10. W.I
3. EMPL	OYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STR	REET:				
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. Z	ZIP:	15. HOME F	PHONE:
5 INSII	RER MAILING AD	DRESS:		16. DATE OF INJ	IIRV·	I 1 7	7. DESCRIPT	IONI OF	IN II IRV		
0	THE TO THE	DREGG.		8/16/		''	. D2001111	.011 01	moorer.		
					1						
FO IF \ ST/				YES  NO	BE	NEFITS	PLOYEE RECI THAT MAY S S; COMPENS	TOP W	/HILE ON		YES  NO
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS	WK					WK	l		
1			19					37			
2			20					38			
3			21				39				
4			22					40			
5			23					41			
6			24					42			
7			25					43	6/18/11		400.00
8			26					44	6/25/11		400.00
9			27					45	7/2/11		400.00
10			28					46	7/9/11		400.00
11			29					47	7/16/11		400.00
12			30					48	7/23/11		400.00
13			31					49	7/30/11		400.00
14			32					50	8/6/11		400.00
15			33					51	8/13/11		400.00
16			34					52	8/20/11		400.00
17			35					21. TOTAL			
18			36					EARNINGS \$ 4,000.00  22. GROSS AVERAGE			
							WEEKLY WAGE			s Unknown	

AWW calculation explanation: Summer camps are seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be obtained and then be divided by 52 weeks. (The wages listed above are for the current calendar year.)

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE		6. SOCIAL SECU	JRITY NU	MBER		7. WCB FILE NUMBER:				
2. EMPI	OYER NAME:			8. EMPLOYEE LA	AST NAM	E:		9. FIR	ST NAME:		10. M.I.:
	S	School							Barne	ey	
3. EMPI	OYER MAILING A	DDRESS AND PHONE	NUMBER:	11. ADDRESS-N	UMBER A	AND STR	EET:	I			I
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. Z	IP:	15. HO	ME PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF IN. 9/26		17	'. DESCRIP	FION OF	FINJURY:		
FO IF `				YES  NO	BE	NEFITS '	LOYEE REC THAT MAY S S; COMPENS	STOP W	/HILE ON		YES
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37			
	10/9/10	750.00		2/12/11		7	750.00		6/18/11	l	750.00
2	10/16/10	750.00		2/19/11		7	750.00	38	6/25/11		0.00
3	10/23/10	750.00		2/26/11		7	750.00	39	7/2/11		0.00
4	10/30/10	750.00	22	3/5/11		7	750.00	40	7/9/11		0.00
5	11/6/10	750.00		3/12/11		7	750.00	41	7/16/11		0.00
6	11/13/10	750.00		3/19/11		7	750.00	42	7/23/11		0.00
7	11/20/10	750.00		3/26/11		7	750.00	43	7/30/11		0.00
8	11/27/10	750.00		4/2/11		7	750.00	44	8/6/11		0.00
9	12/4/10	750.00		4/9/11		7	750.00	45	8/13/11		0.00
10	12/11/10	750.00		4/16/11		7	750.00	46	8/20/11		0.00
11	12/18/10	750.00		4/23/11		7	750.00	47	8/27/11		0.00
12	12/25/10	750.00	30	4/30/11		7	750.00	48	9/3/11		800.00
13	1/1/11	750.00		5/7/11		7	750.00	49	9/10/11		800.00
14	1/8/11	750.00		5/14/11		7	750.00	50	9/17/11		800.00
15	1/15/11	750.00		5/21/11		7	750.00	51	9/24/11		800.00
16	1/22/11	750.00	34	5/28/11		7	750.00	52	10/1/11		800.00
17	1/29/11	750.00		6/4/11	750.00 21. TOTAL EARNINGS				RNINGS		31,750.00
18	2/5/11	750.00	36	6/11/11	Ţ	-	750 00	22. GR	OSS AVERAGE		755 05

AWW calculation explanation: Most teachers and other school personnel do not work at least 200 full workdays during a calendar year. Therefore,  $\S102(4)(A)$  cannot be used in those situations. Based on the actual circumstances of the employment,  $\S102(4)(B)$  might produce a fair and reasonable AWW (Total Earnings divided by 42 weeks = \$755.95.) If it does not, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW ( $\S102(4)(D)$ ). [ $\S102(4)(C)$  cannot be used because schools are not seasonal employers.]

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMPI		Office		8. EMPLOYEE L/	AST NAI	ME:		9. FIR	ST NAME:	e	10. M.I.:
3. EMPI	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	R: 11. ADDRESS-N	UMBER	AND STREE	Т:				
4. INSUI	RER NAME:			12. CITY:		13.	. STATE	: 14. Z	IP:	15. HOME	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJ		17. DI	ESCRIP <sup>*</sup>	TION OF	FINJURY:		
FO IF ` ST.				YES NO	ВІ	OES EMPLO ENEFITS THA VORKERS; CO	YAM TA	STOP W	HILE ON		YES   NO
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	10/16/10	600.00	19	2/19/11		600	0.00	37	6/25/11		650.00
2	10/23/10	600.00	20	2/26/11		600	0.00	38	7/2/11		650.00
3	10/30/10	600.00	21	3/5/11		600	0.00	39	7/9/11		650.00
4	11/6/10	600.00	22	3/12/11		600	0.00	40	7/16/11		650.00
5	11/13/10	600.00	23	3/19/11		600	0.00	41	7/23/11		650.00
6	11/20/10	600.00	24	3/26/11		600	0.00	42	7/30/11		650.00
7	11/27/10	600.00	25	4/2/11		650	0.00	43	8/6/11		650.00
8	12/4/10	600.00	26	4/9/11		650	0.00	44	8/13/11		650.00
9	12/11/10	600.00	27	4/16/11		650	0.00	45	8/20/11	ı	650.00
10	12/18/10	600.00	28	4/23/11		650	0.00	46	8/27/11		650.00
11	12/25/10	800.00	29	4/30/11		650	0.00	47	9/3/11		650.00
12	1/1/11	600.00	30	5/7/11		650	0.00	48	9/10/11	ı	650.00
13	1/8/11	600.00	31	5/14/11		650	0.00	49	9/17/11		650.00
14	1/15/11	600.00	32	5/21/11			0.00	50	9/24/11		650.00
15	1/22/11	600.00	33	5/28/11			0.00	51	10/1/11		650.00
16	1/29/11	600.00	34	6/4/11			0.00	52	10/8/11		650.00
17	2/5/11	600.00	35	6/11/11		650	0.00	21. TOT	AL	s 32	,800.00
18	2/12/11	600.00	36	6/18/11		650	0.00	22. GR	OSS AVERAGE		0.00

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was \$650.00.

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECU	RITY NU	JMBER	7. \	WCB FILE NUM	IBER:	
2. EMPI		Sales		8. EMPLOYEE LA	AST NAM	ΛE:	9. FIF	RST NAME:  Brian		10. M.I.:
3. EMPI		ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NI	JMBER .	AND STREET:		Bilaii		
4. INSUF	RER NAME:			12. CITY:		13. STAT	E: 14. 2	ZIP: 1	5. HOME F	PHONE:
5 INIQUI	RER MAILING ADI	DDESS:		16. DATE OF INJ	I IDV:	17. DESCRI	DTION O	E IN II IDV:		
3. 11400	NEIN MAILING ADI	DRESS.		11/3/	_	Tr. BESSIN	i iloli o	i ingoici.		
FO	ES EMPLOYEE W R ANOTHER EMP	LOYER?		YES 🗆		DES EMPLOYEE R ENEFITS THAT MA				YES 🗆
ST		YER SHALL SUBMIT A V EACH ADDITIONAL EMI		NO 🗌	W	ORKERS; COMPE	NSATION	l?.		NO 🗆
20. <b>WK</b>		GROSS EARNINGS	WK				WK			
1	11/13/10	500.00	19	3/1	9/11	900.00		7/23/1	1	730.00
2	11/20/10	600.00	20	3/26/11 775.00			38	7/30/1	1	1500.00
3	11/27/10	400.00	21	4/	700.00	39	8/6/1	1	1000.00	
4	12/4/10	700.00	22	4/	9/11	950.00	40	8/13/1	1	600.00
5	12/11/10	875.00	23	4/1	900.00		8/20/1	1	600.00	
6	12/18/10	825.00	24	4/2	3/11	675.00	42	8/27/1	1	725.00
7	12/25/10	775.00	25	4/3	0/11	725.00	43	9/3/1	1	775.00
8	1/1/11	800.00	26	5/	7/11	700.00	44	9/10/1	1	800.00
9	1/8/11	700.00	27	5/1	4/11	800.00	45	9/17/1	1	775.00
10	1/15/11	825.00	28	5/2	1/11	900.00	46	9/24/1	1	950.00
11	1/22/11	750.00	29	5/2	8/11	850.00	47	10/1/1	1	850.00
12	1/29/11	900.00	30	6/	4/11	900.00		10/8/1	1	600.00
13	2/5/11	950.00	31	6/1	1/11	1000.00	49	10/15/1	1	710.00
14	2/12/11	875.00	32	6/1	8/11	800.00		10/22/1	1	895.00
15	2/19/11	950.00	33	6/2	5/11	925.00	51	10/29/1	1	1000.00
16	2/26/11	700.00	34	7/2/11		850.00	52	11/5/1	1	600.00
17	3/5/11	800.00	35	7/	9/11	750.00		RNINGS	s 41,	,705.00
18	3/12/11	800.00	36		6/11	770.00	22. GROSS AVERAGE		, 80	5.98

AWW calculation explanation: This employee's semi-monthly earnings generally varied, so §102(4)(A) cannot be used. The week ending 11/5/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$41,105.00) should then be divided by 51 weeks (§102(4)(B)).

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER:     EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMP		Office		8. EMPLOYEE LA	AST NAM	1E:		9. FIR	ST NAME: Adar	n	10. M.I.:
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	: 11. ADDRESS-NU	UMBER A	AND STR	EET:				
4. INSUI	RER NAME:			12. CITY:			13. STATE	: 14. Z	IP:	15. HOME	: PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJ		17	l 7. DESCRIP	TION OF	FINJURY:		
FO IF				YES NO	BE	NEFITS	LOYEE REC THAT MAY S; COMPENS	STOP W	/HILE ON		YES   NO
WK 1	WEEK ENDING 11/20/10	GROSS EARNINGS 550.00	WK 19	3/26/11		į	550.00	WK 37	7/30/11	1	600.00
2	11/27/10	550.00	20	4/2/11			550.00	38	8/6/11		600.00
3	12/4/10	550.00	21	4/9/11		į	550.00	39	8/13/11	1	600.00
4	12/11/10	550.00	22	4/16/11	40			40	8/20/11	1	600.00
5	12/18/10	550.00	23	4/23/11		Ę	550.00	41	8/27/11	1	600.00
6	12/25/10	550.00	24	4/30/11		į	550.00	42	9/3/11		575.00
7	1/1/11	650.00	25	5/7/11		Ę	550.00	43	9/10/11	1	600.00
8	1/8/11	550.00	26	5/14/11		6	600.00	44	9/17/11	1	600.00
9	1/15/11	550.00	27	5/21/11		6	600.00	45	9/24/11	1	600.00
10	1/22/11	550.00	28	5/28/11		(	00.00	46	10/1/11	1	600.00
11	1/29/11	550.00	29	6/4/11		(	00.00	47	10/8/11	1	600.00
12	2/5/11	550.00	30	6/11/11		(	00.00	48	10/15/1	11	600.00
13	2/12/11	550.00	31	6/18/11		(	600.00	49	10/22/1	11	600.00
14	2/19/11	550.00	32	6/25/11		8	300.00	50	10/29/1	11	650.00
15	2/26/11	550.00	33	7/2/11		6	600.00	51	11/5/11	1	650.00
16	3/5/11	550.00	34	7/9/11		(	600.00	52	11/12/1	11	130.00
17	3/12/11	550.00	35	7/16/11		(	600.00	21. TOT EAF		\$ 29	9,855.00
18	3/19/11	550.00	36	7/23/11		6	600.00	22. GROSS AVERAGE			50.00

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was \$650.00.

### WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:				6. SOCIAL SECURITY NUMBER					7. WCB FILE NUMBER:				
2. EMPLOYER NAME:				8. EMPLOYEE LAST NAME:					9. FIRST NAME: 10. I				
		p Agency Bill											
3. EMPI	LOYER MAILING A	11. ADDRESS	11. ADDRESS-NUMBER AND STREET:										
4. INSUI	RER NAME:			12. CITY:			13. STATE	14. 2	ZIP:	15. HOME	PHONE:		
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF	INJURY: 10/11		17. DESCRIP	TION O	F INJURY:				
				11/	10/11								
FO	ES EMPLOYEE W R ANOTHER EMP	LOYER?	NA 05	YES	'   '	BENEFIT	IPLOYEE REC	STOP V	VHILE ON		YES 🗆		
ST		YER SHALL SUBMIT A V EACH ADDITIONAL EMI		NO	J	WORKER	RS; COMPENS	SATION	· · · · · · · · · · · · · · · · · · ·		NO 🗆		
20. <b>WK</b>	WEEK ENDING	GROSS EARNINGS	WK					WK					
1	11/20/10	600.00	19	3/26/11			0.00	37	7/30/11		0.00		
2	11/27/10	600.00	20	4/2/11			0.00	38	8/6/11		500.00		
3	12/4/10	500.00	21	4/9/11			0.00	39	8/13/11		900.00		
4	12/11/10	600.00	22	4/16/11			200.00	40	8/20/11		900.00		
5	12/18/10	500.00		4/23/11			400.00	41	8/27/11		850.00		
6	12/25/10	550.00		4/30/11			600.00	42	9/3/11		825.00		
7	1/1/11	625.00		5/7/11			600.00	43	9/10/11		850.00		
8	1/8/11	0.00		5/14/11			600.00	44	9/17/11		800.00		
9	1/15/11	0.00		5/21/11			600.00	45	9/24/11		750.00		
10	1/22/11	0.00		5/28/11			600.00	46	10/1/11		900.00		
11	1/29/11	0.00		6/4/11			200.00	47	10/8/11		450.00		
12	2/5/11	300.00		6/11/11			0.00	48	10/15/1	1	500.00		
13	2/12/11	800.00		6/18/11			0.00	49	10/22/1	1	0.00		
14	2/19/11	800.00		6/25/11			0.00	50	10/29/1	1	0.00		
15	2/26/11	750.00		7/2/11			0.00	51	11/5/11		200.00		
16	3/5/11	750.00	34	7/9/11			0.00	52	11/12/1	1	450.00		
17	3/12/11	800.00	35	7/16/11			0.00	21. TO	TAL RNINGS	s 21	,350.00		
18	3/19/11	500.00	36	7/23/11			0.00		OSS AVERAGE		4.71		

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. There were no earnings during the weeks ending 1/8/11, 1/15/11, 1/22/11, 1/29/11, 3/26/11, 4/2/11, 4/9/11, 6/11/11, 6/18/11, 6/25/11, 7/2/11, 7/9/11, 7/16/11, 7/23/11, 7/30/11, 10/22/11 and 10/29/11, so those weeks must be excluded. The week ending 11/12/11 includes the date of injury and reduces the AWW, so it too should be excluded, and the remainder (\$20,900.00) should be divided by 34 weeks (§102(4)(B)). [If, based on the actual circumstances of the employment, §102(4)(B) does not produce a fair and reasonable AWW, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW (§102(4)(D)). §102(4)(C) cannot be used because temp agencies are not seasonal employers.]

### APPENDIX C: ADDITIONAL NOC INFORMATION

	Full Denial Reason Codes (DN198)							
1	No Comp	ensable Accident						
	A	Coming and Going						
	В	Horseplay						
	С	Willful Intent to Injure Oneself						
	D	Does Not Meet Statutory Definition of Accident						
	Е	Deviation From Employment						
	F	Recreational/Social Activity						
	G	Traveling Employee						
	Н	Subsequent Intervening Accident						
2	No Causa	al Relationship						
	A	Idiopathic Condition						
	В	Pre-existing Condition						
	С	Stress Non-Work Related						
	D	No Medical Evidence of Injury						
	Е	No Injury Per Statutory Definition						
	F	Accident Not Major Contributing Cause of Injury						
3	No Cover							
	A	No Employer/Employee Relationship						
	В	Independent Contractor						
	C	Does Not Meet Statutory Definition of Employee						
	D	No Jurisdiction						
	Е	No Policy in Effect on the Date of Accident						
	F	Statute of Limitation Expired						
	G	Statutory Exemptions (Sole Proprietor, Corporate Officer, etc.)						
	Н	Elected Other Coverage (24 hour, Collective Bargaining, Opted Out)						
4	Substanc							
	A	Injury Primarily Occasioned by Intoxication or Use of Any Drug						
5	Other (N	ot Elsewhere Classified)						
	A	Failure to Report Accident Timely						
	C	Misrepresentation						

Partial Denial Reason Codes (DN294)							
A	Denying Indemnity in Whole, not Medical						
В	Denying Indemnity in Part, not Medical						
C	Denying Medical in Whole, Not Indemnity						
D	Denying Medical in Part, Not Indemnity						
E	Denying Indemnity in Whole, Medical in Part						
F	Denying Medical in Whole, Indemnity in Part						
G	Denying Both Indemnity & Medical in Part						

#### NOTICE OF CONTROVERSY

WCB FILE # (if known): DN5 THIS IS A DENIAL OF YOUR BENEFITS (Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.) EMPLOYEE EMPLOYEE LAST NAME FIRST NAME . EMPLOYEE ID **DN43 & DN255 DN44 DN45** DN(42/152/153/154/156) 10. HOME PHONE #: DN270 STREET/P.O. BOX MAILING ADDRESS CITY . STATE NA - DN46 will print all NA boxes with data **NA - DN48** NA - DN50 NA - 51 NA - DN49 11. DATE OF INJURY: 12. SPECIFIC INJURY OR ILLNESS 13. BODY PART(S) AFFECTED: **DN31** NA-DN35 **NA - DN36 EMPLOYER** 4. INSURER/CLAIM ADMIN FILE #: 15. EMPLOYER NAME: 6. EMPLOYER MAILING ADDRESS AND PHONE #: **DN15 NA - DN18** NA - DN168, 165, 170, 167, and 159 17. INSURER/CLAIM ADMIN NAME AND ADDRESS: 18 INSURER/CLAIM ADMIN FEIN DN188, NA – DN10, 12, 13, and 14 **DN187** NOTICE TO EMPLOYEE YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW.

IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW. **FULL DENIAL REASON** PARTIAL DENIAL REASON **DN294 DN198** DATE OF INITIAL INCAPACITY \_\_\_/DN56/\_ CURRENT DATE OF INCAPACITY /DN144/ FULL DENIAL EFFECTIVE DATE \_\_\_/DN199\_/\_ DATE EMPLOYER NOTIFIED \_\_\_\_/DN281\_/\_ \*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.
21. COMMENTS: DN197 22. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S. § 205(2) and in compliance with 39-A M.R.S. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met: A. The employer files a Notice of Controversy; and B. The employer pays benefits from the date the claim is made. Payment under Rule 1.1 requires filing of a Memorandum of Payment. 
 ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

 FA
 BANGOR
 CARIBOU
 LEWISTON

 STE 102
 106 HOGAN RD
 ONE VAUGHN PL
 36 MOLLLISON WAY

 ME
 BANGOR, ME
 43 HATCH DR, STE 110
 LEWISTON, ME
 AUGUSTA
24 STONE ST, STE 102
AUGUSTA, ME PORTLAND 62 ELM ST PORTLAND, ME 04330-5220 (207) 287-2308 04401-5638 (207) 941-4550 CARIBOU, ME 04736 (207) 498-6428 04240-7777 (207) 753-7700 04101-3061 (207) 822-0840 1-800-400-6854 1-800-400-6856 1-800-400-6855 1-800-400-6857 1-800-400-6858 23. NAME (TYPE OR PRINT) TELEPHONE #: 25. DATE SENT TO WCB **DN140 DN137** \_/DN100\_/ -MAIL ADDRESS: 26. DATE RCVD AT THE WCB (WCB use only): **DN138** 

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-9 (eff. 1/1/13)

	ICE OF CON	OUR BENEFITS		ata elements )	1. V	VCB FILE# (if known): DN5
(1vote: the D1v 1vumbers represen	it a crosswark to the 174	EMPLOYEE	isc 5 LDI 0	ata cicincitis.)		
E. EMPLOYEE LAST NAME:	<ol><li>FIRST NAME:</li></ol>			5. EMPLOYEE ID		
DN43		DN44	DN45	TYPE DN270	# DN(42/15	52/153/154/156)
. STREET/P.O. BOX MAILING ADDRESS: NA - DN46 (will print all NA boxes witblata from FR	7. CITY: NA – DN	8. ST/ NA	TE: 9 - DN49	9. ZIP: NA – DN50	10. HOME PHON	#: IA - 51
DN31/	12. SPECIFIC INJURY	OR ILLNESS: NA-DN35		13. BO	DY PART(S) AFFE NA – [	
		EMPLOYER				
. INSURERCLAIM ADMIN FILE#: 15. DN15	EMPLOYER NAME: NA – DN18			AILING ADDRESS A – DN168, 16		nd 159
7. INSURERCLAIM ADMIN NAME AND ADD $\overline{ m DN188}$	ress: JA-DN10, 12, 1	13, and 14		18. INSURER	RCLAIM ADMIN FEI DN18	
19.	N	NOTICE TO EMPL	O YEE	I		
YOUR EMPLOYER/INSURER IS DEN						
a.		19b.	LUINLIOT A		ENIAL REASON	
FULL DENIA				FARTIAL	LINGREN TRIBIT	•
DN19 Values (Enter no more						
1 (A,B,C,D,E,F,G or H	)					
2 (A,B,C,D,E or F)		20a.	TAUTUAL DIS	NADACITY '		
3 (A,B,C,D,E,F,G,or H	)			CAPACITY <i></i> NCAPACITY/_		
4 (A)		20b.				
		DATE EN	MPLOYER NO	OTIFIED//		
5 (A or C) ULL DENIAL EFFECTIVE DATE/DN19	9 /					
NOTE: Reasons identified in boxes 19a or 19 iditional issues at a later date.	b will not preclude a party in					
1.		COMMENTS:				
		DNI407/Enter normal	:\			
		DN197 (Enter narrat	ive)			
<ol><li>IF THIS DENIAL NOTICES NOTTIM to date of incapacity in accordance with 38. M</li></ol>						
utomatically ceases upon the filing of a Notice						
ASSISTANCE IS AVAIL	ABLE AT THE MAINE	WORKERS' COMP	ENSATION	BOARD'S REG	IONAL OFFICE	S
AUGUSTA 24 STONE STSUITE 2 AUGUSTA, ME	BANGOR 106 HOGAN ROAD BANGOR, ME	CARIBOU 43 HATCH DRI CARIBOO, ME	VSEUITE 110	LEWISTON 36 MOLLISON WA LEWISTON, ME	AY 62 EI PORT	TLAND .M ST. 'LAND, ME
04336220 (207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525	044045638 (207)941-4550 1-800-400-6856	047362347 (207)4986428 1-800-400-6855		042495811 (207)53-7700 1800-400-6857	(207)	1-3061 3220840 100-6858
3. NAME (TYPE OR PRINT):		24. TELEPHONE #:		25. D	ATE SENT TO WCE	:
DN140		( )	1127	20. 0.		
		l Di	N137		,DN10	U_/
		1		26 D/	ATE ROVD AT THE	WCB (WCB use only)
E-MAIL ADDRESS:  DN138				20. 07	/_	/

FULL DENIAL OF A LOST TIME C	CLAIM									
	E OF CONT A DENIAL OF YO a crosswalk to the IA	UR BENE	FITS	DI da	ata element	ts.)	WCB FILE # (if known):     DN5			
		EMPLO	'EE							
EMPLOYEE LAST NAME:     DN43     STREET/P.O. BOX MAILING ADDRESS:	3. FIRST NAME:  DN  7. CITY:	<b>N</b> 44	4. MI: DN45		DN270	#:	DN(42/152/153/154/156) ME PHONE #:			
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN4		NA – DN49		A – DN50		NA - 51			
11. DATE OF INJURY: 12. SPECIFIC INJURY OR ILLNESS: 13. BODY PART(S) AFFECTED: NA – DN36										
EMPLOYER										
14. INSURER /CLAIM ADMI N FILE #: 15. EMF  DN15	PLOYER NAME: NA – DN18		16. EMPLOYER MAI				#: '0, 167, and 159			
17. INSURER/ CLAIM ADMIN NAME AND ADDRESS:  DN188, NA	– DN10, 12, 13, an	nd 14			18. INSURER/	CLAIM	ADMIN FEIN: DN187			
19. YOUR EMPLOYER/INSURER IS DENYING YOU IF YOU DISAGREE WITH THIS DENIAL	UR WORKERS' COMPENSAT	TON CLAIM OF								
19a. FULL DENIAL REA	ASON	19	ðb.		PARTIAL DI	ENIAL F	REASON			
DN198 Values (Enter no more t	han five):									
1 (A,B,C,D,E,F,G or H)		20								
2 (A,B,C,D,E or F)			ATE OF INITIAL INC	CAPAC	:ITY/ <b>DN</b>	N56/				
3 (A,B,C,D,E,F,G,or H)		С	URRENT DATE OF							
4 (A)		Ī	ATE EMPLOYER NOT	IFIED	/ DI	N281∠	<u></u>			
5 (A or C) FULL DENIAL EFFECTIVE DATE /DN199_/_										
*NOTE: Reasons identified in boxes 19a or 19b will not pre additional issues at a later date.	eclude a party from raising									
21.		COMMENT	<u>S:</u>							
	<u>D</u>	N197 (Enter	narrative)							
22. IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1 , the employee must be pai d total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with 39 -A M.R.S.A. § 205(2) and in compliance with 39 -A M.R.S.A. § 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a Notice of Controversy and the payment of any accrued benefits.  Payment under Rule 1.1 requires filing of a Memorandum of Payment.										
ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES  AUGUSTA BANGOR CARIBOU LEW ISTON PORTLAND										
24 STONE ST. SUITE 2 106 AUGUSTA, ME BA. 04330 - 5220 044 (207)287 - 2308 (Voice) (20' 1-800-400-6864 (Voice) 1-8 TTY 1 -877-832 -5525	HOGAN ROAD NGOR, ME 01 -5638 7)941 -4550 900-400-6856	CARIBOU 43 HATCH DRI CARIBOU, M 04736 -234 (207)498 -6 1 -800-400-	VE SUITE 110 IE 17 1428 6855	36 M LEWIS 04240 (207)7	OLLISON WAY 5TON, ME 1 -5811 7 53-7700 0-400-6857		PORTLAND 62 ELM ST. PORTLAND, ME 04101 -3061 (207)822 -0840 1 -800 -400 -6858			
23. NAME (TYPE OR PRINT):  DN140	2	4. TELEPHON	E#: DN137		25. D	ATE SEN	T TO WCB: _/ DN100_/			
E-MAIL ADDRESS:  DN138					26. DA	TE RCVI	D AT THE WCB (WCB use only) :			

WCB -9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, o r activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: 1 -888-801-9087 or TTY (877) 832 -5525.

DISTRIBUTION: COPY (1) EMPLOYEE, ( 2) EMPLOY ER

DN43  DN44  DN45  Type DN270 #: DN(42/153/154/1  8. STREET/P.O. BOX MAILING ADDRESS: NA - DN46  (will print all NA boxes withdata from FROI)  11. DATE OF INJURY: DN31  12. SPECIFIC INJURY OR ILLNESS: NA-DN35  13. BODY PART(S) AFFECTED: NA - DN36  EMPLOYER  14. INSURERCLAIMADMINFILE#: DN15  15. EMPLOYER NAME: NA - DN18  16. EMPLOYER MAILING ADDRESS AND PHONE NA - DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMINNAME AND ADDRESS: DN188NA - DN10, 12, 13, and 14  19. YOUR EMPLOYER IS DENYING YOUR WORKERS COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELC	
EMPLOYEE LAST NAME: DN43  S. FIRST NAME: DN44  S. STREET/P.O. BOX MALLING ADDRESS: NA - DN46  (will print all NA boxes withtata from FROI)  11. DATE OF INJURY: DN31  12. SPECIFIC INJURY OR ILLNESS: NA - DN18  14. INSURERCLAIM ADMINFILE#: DN15  15. EMPLOYER NAME: NA - DN18  16. EMPLOYER NA - DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMINNAME AND ADDRESS: DN188NA - DN10, 12, 13, and 14  19. YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELCOMB.  19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G	wn):
2. EMPLOYEE LAST NAME: DN43  6. STREET/P.O. BOX MAILING ADDRESS: NA – DN46 (will print all NA boxes withtata from FROI)  11. DATE OF INJURY: DN31  12. SPECIFIC INJURY OR ILLNESS: NA – DN15  EMPLOYER  14. INSURERCLAIM ADMINIFILE#: DN15  15. EMPLOYER NAME: NA – DN18  16. EMPLOYER MAILING ADDRESS AND PHONE NA – DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMININAME AND ADDRESS: DN188NA – DN10, 12, 13, and 14  19. YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELCOME.  PARTIAL DENIAL REASON  DN294 Values = A,B,E,F or G	
6. STREET/P.O. BOX MAILING ADDRESS: NA – DN48  (will print all NA boxes withdata from FROI)  11. DATE OF INJURY: DN31  12. SPECIFIC INJURY OR ILLNESS: NA-DN35  13. BODY PART(S) AFFECTED: NA – DN36  EMPLOYER  14. INSURERCLAIMADMINFILE#: DN15  15. EMPLOYER NAME: NA – DN18  16. EMPLOYER MAILING ADDRESS AND PHOME NA – DN168, 165, 170, 167, and 159  17. INSURERCLAIMADMINNAME AND ADDRESS: DN10, 12, 13, and 14  19. NOTICE TO EMPLOYEE  YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELC 19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G	56)
11. DATE OF INJURY:  DN31  12. SPECIFIC INJURY OR ILLNESS: NA-DN35  13. BODY PART(S) AFFECTED: NA - DN36   EMPLOYER  14. INSURERCLAIMADMINFILE#: DN15  15. EMPLOYER NAME: NA - DN18  16. EMPLOYER MAILING ADDRESS AND PHONE NA - DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMINNAME AND ADDRESS: DN188NA-DN10, 12, 13, and 14  19.  NOTICE TO EMPLOYEE YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELC  19a.  FULL DENIAL REASON  DN294 Values = A,B,E,F or G	KI)
14. INSURERCLAIMADMINFILE#: DN15  15. EMPLOYER NAME: NA - DN18  16. EMPLOYER MAILING ADDRESS AND PHOME NA - DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMINNAME AND ADDRESS: DN188NA-DN10, 12, 13, and 14  19. YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELC  19a.  FULL DENIAL REASON  DN294 Values = A,B,E,F or G	
DN15  NA - DN18  NA - DN168, 165, 170, 167, and 159  17. INSURERCLAIM ADMINNAME AND ADDRESS:  DN188NA-DN10, 12, 13, and 14  19.  YOUR EMPLOYERINSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELD  19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G	
DN188NA-DN10, 12, 13, and 14  19.  YOUR EMPLOYERINSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELD  19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G	
YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKE IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELD  19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G	
19a.  FULL DENIAL REASON  DN294  Values = A,B,E,F or G  20a.	D BELOW W.
Values = A,B,E,F or G	
T <sup>os.</sup>	
DATE OF INITIAL INCAPACITYUN56/	
CURRENTDATEOF INCAPACITY/ 20b.	
FULL DENIAL EFFECTIVE DATE _//	
*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.  DATE EMPLOYER NOTIFIEDDN281_/	
21. COMMENTS:	
DN197(Enter narrative)	
22. IF THIS DENIAL NOTICES NOTTIMELY PURSUANT TO RULE 1.the employee must be pail total benefits, with credit for earnings and other statutory, the date of incapacity in accordance with 39M.R.S.A. § 205(2) and in compliance with 39M.R.S.A. § 204. The requirement for payment of benefits under this subsect automatically ceases upon the filing of a Notice of Controversy and the paymeans/faccrued benefitsPaymentunderRule 1.1 requires filing of a Memorandum of Paymentum of	tion
ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES	
AUGUSTA         BANGOR         CARIBOU         LEWISTON         PORTLAND           24 STONE STSUITE 2         106 HOGAN ROAD         43 HATCH DRISUITE 110         36 MOLLISON WAY         62 ELM ST.           AUGUSTA, ME         BANGOR, ME         CARIBOU, ME         LEWISTON, ME         PORTLAND, ME           043362200         04406638         047362347         042466811         041013061           (2077282308 (Voice)         (207)9414550         (207)498428         (207)85-7700         (207)8220840           1-800400-6854 (Voice)         1-800-400-6856         1800-400-6855         1800-400-6857         1800-400-6858	
23. NAME (TYPE OR PRINT):  DN140  24. TELEPHONE #:  ( )  DN137  DN100 /	
E-MAIL ADDRESS:  DN138  26. DATE RCVD AT THE WCB (WCB use	only)

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, actaesor operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephase301-9087 or TTY (877) 832525.

DISTRIBUTION COPY (1) EMPLOYEE,2) EMPLOYER

(Note: the DN Numbers repres	S IS A DENIA		NEFITS					ILE# (if known): DN5
. EMPLOYEE LAST NAME: DN43	3. FIR	ST NAME: DN44	4. MI: DN4		IPLOYEE ID			
		DN44		TYPE	DN270 #			3/154/156)
. STREET/P.O. BOX MAILING ADDRESS NA – DN46		NA – DN48	8. STATE: NA – DN4	9. ZII 19 NA	P: A – DN50	). HOME	`PHONE#: NA - 5	51
(will print all NA boxes with data from FR	(OI)							
DN31/	12. SPECIFI	TIC INJURY OR ILLNE NA-DN			13. BODY		NA – DN36	
		EMP	LOYER					
. INSURERCLAM ADMINFILE#: 15 DN15	5. EMPLOYER NA NA	AME: . – DN18	16. EMPLOY		NG ADDRESS A DN168, 165			59
7. INSURERCLAIMADMINNAMEAND AD	DRESS:		u u		18. INSURERC			
DN188	NA-DN10	), 12, 13, and	1 14				DN187	
19.		NOTICE 7	TO EMPLOYE	<u> </u>				
YOUR EMPLOYER/INSURER IS D IF YOU DISAGREE WITH THE	ENYING YOUR W	ORKERS' COMPENS	SATION CLAIM OR	PART OF	FIT. THE REASO	ON FOR	THE DENIAL	IS CHECKED BELL
9a.		TACT A CLAIMS RES	19b.	LIOI AI				OTED DELUW.
FULL DENIAL	- KEASUN				PARTIAL DENI	AL REAS	OUN	
					DN2	294		
					Values =		)	
			20a.					
			DATE OF INITIA	INICADA	ACITY //			
			DATE OF INITIA					
AND DENIAL EFFECTIVE DATE								
			CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//	<del>-</del> 		
NOTE: Reasons identified in boxes 19a or		de a party from raising	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//	<u>-</u>		
IOTE: Reasons identified in boxes 19a or iditional issues at a later date.			CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//			
IOTE: Reasons identified in boxes 19a or dditional issues at a later date.		de a party from raising	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//			
IOTE: Reasons identified in boxes 19a or dditional issues at a later date.		СОММЕ	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//			
NOTE: Reasons identified in boxes 19a or dditional issues at a later date.		СОММЕ	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//			
IOTE: Reasons identified in boxes 19a or dditional issues at a later date.		СОММЕ	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//	<u>-</u>		
NOTE: Reasons identified in boxes 19a or dditional issues at a later date.		СОММЕ	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY//			
NOTE: Reasons identified in boxes 19a or dditional issues at a later date.		СОММЕ	CURRENTDATE 20b.  DATE EMPLOYE	OFINCA	PACITY/_/			
NOTE: Reasons identified in boxes 19a or ditional issues at a later date.  1.  2. IF THIS DENIAL NOTICE IS NOT TIME	19b will not preclud	DN197 (Er	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  atter narrative)	OF INCAL	PACITY/_/	iit for earr	ings and othe	or statutory offsets,
IOTE: Reasons identified in boxes 19a or iditional issues at a later date.  . IF THIS DENIAL NOTICE IS NOT TIME ed ab of incapacity in accordance with 391	19b will not preclud  MELY PURSUANT  M.R.S.A.§ 205(2) a	COMME  DN197 (Er	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  nter narrative)  employee must be 390M.R.S.A. § 204	OF INCAL  R NOTIF	PACITY	lit for earr	enefits under	this subsection
IOTE: Reasons identified in boxes 19a or diditional issues at a later date.  1. 2. IF THIS DENIAL NOTICE IS NOT TIME of the property of the period of the pe	19b will not preclud  MELY PURSUANT  M.R.S.A.§ 205(2) a	COMME  DN197 (Er	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  nter narrative)  employee must be 390M.R.S.A. § 204	OF INCAL  R NOTIF	PACITY	lit for earr	enefits under	this subsection
NOTE: Reasons identified in boxes 19a or dditional issues at a later date.  1.  2. IF THIS DENIAL NOTICE IS NOT TIMe date of incapacity in accordance with 39 utomatically ceases upon the filing of a Notice IS NOT TIME.	19b will not preclud  MELY PURSUANT  M.R.S.A.§ 205(2) a  tice of Controversy	COMME  DN197 (Er  T TO RULE 1.1 , the and in compliance with y and the payment of a	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  nter narrative)  employee must be 1 39 M.R.S.A. § 204 anyeddænefits Paym	OF INCAL  R NOTIF  Palitotal be The req entunder	enefits, with cred uirement for pay Rule 1.1 requires	lit for earr ment of b filing of a	enefits under a Memorandur	this subsection
ULL DENIAL EFFECTIVE DATE/_ NOTE: Reasons identified in boxes 19a or diditional issues at a later date.  1.  2. IF THIS DENIAL NOTICE IS NOT TIME date of incapacity in accordance with 39 utomatically ceases upon the filing of a Notice IS AVA	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy	DN197 (Er  TTO RULE 1.1 , the and in compliance with y and the payment of a	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  Inter narrative)  employee must be a90 M.R.S.A. § 204 angeddmenefits Paym	of Incal ER NOTIF  palitotal be. The req entunder!	enefits, with cred uirement for pay Rule1.1 requires	lit for earr ment of b filing of a	Memorandur	this subsection m of Payment.
NOTE: Reasons identified in boxes 19a or diditional issues at a later date.  1.  2. IF THIS DENIAL NOTICE IS NOT TIME to the capacity in accordance with 490 utomatically ceases upon the filing of a Notational Notation ASSISTANCE IS AVAILABLE AUGUSTA 24 STONE SEUITE 2	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAN R	DN197 (Er  TTO RULE 1.1 , the and in compliance with y and the payment of a lie MAINE WORKE CARIL COAD 43	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  Inter narrative)  employee must be 39 M.R.S.A. § 204 angeddænefitsPaym  ERS' COMPENS. BOU HATCH DRBUBTE	of Incal ER NOTIF  palitotal be The req entunder!	enefits, with cred uirement for pay Rule1.1 requires	lit for earn ment of b filling of a	OFFICES  PORTLANI 62 ELM ST.	this subsection m of Payment.
IOTE: Reasons identified in boxes 19a or iditional issues at a later date.  2. IF THIS DENIAL NOTICE IS NOT TIME of the date of incapacity in accordance with 30 itomatically ceases upon the filing of a Notational Control of the ASSISTANCE IS AVAILUSTA 24 STONE STUITE 2 AUGUSTA, ME	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy NLABLE AT TH BANGOR 106 HOGAN R. BANGOR, ME	DN197 (Er  TTO RULE 1.1 , the and in compliance with y and the payment of a second sec	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  Inter narrative)  employee must be a 39 M.R.S.A. § 204 anyeddoenefits Paym  ERS' COMPENS.  BOU HATCH DR&UBTE IBOU, ME	palitotal be. The requestion of the requestion o	enefits, with cred enefits, with cred diuirement for pay Rule 1.1 requires BOARD'S REC WISTON MOLLISON WAY WISTON, ME	lit for earn ment of b filling of a	OFFICES  PORTLANI 62 ELM ST. PORTLAND	this subsection m of Payment.
OTE: Reasons identified in boxes 19a or iditional issues at a later date.  I. IF THIS DENIAL NOTICE IS NOT TIME at date of incapacity in accordance with 39 itomatically ceases upon the filling of a Notable ASSISTANCE IS AVAINGUSTA  AUGUSTA 24 STONE SEUITE 2 AUGUSTA, ME 04336220 (207)282308 (Voice)	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAIN R BANGOR, ME 0440\$638 (207)9414550	COMME  DN197 (Er  TO RULE 1.1 , the and in compliance with y and the payment of a second seco	currentDate 20b.  DATE EMPLOYE  ENTS:  employee must be a 39 M.R.S.A. § 204 anyeddozenefits Paym  ERS' COMPENS. BOU HATCH DR&UETE 180U, ME 36347 1498428	politotal bo The requestion of	enefits, with cred quirement for pay Rule1.1 requires BOARD'S REC WISTON MOLLISON WAY WISTON, ME 2466811 17/93-7700	lit for earn ment of b filling of a	OFFICES  PORTLANI 62 ELM ST. PORTLAND 04101-3061 (207)822084	this subsection m of Payment.  D  D, ME
OTE: Reasons identified in boxes 19a or iditional issues at a later date.  2. IF THIS DENIAL NOTICE IS NOT TIMe date of incapacity in accordance with 39 intomatically ceases upon the filing of a Notionatically ceases upon the SISUAL AUGUSTA, 24 STONE SISUITE 2 AUGUSTA, ME 04336220	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MILABLE AT TH BANGOR 106 HOGAN R BANGOR, ME 04405638	COMME  DN197 (Er  TO RULE 1.1 , the and in compliance with y and the payment of a second seco	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  employee must be 39 M.R.S.A. § 204 anyeddozenefits Paym  ERS' COMPENS. BOU HATCH DR&UETE IBOU, ME 38347	politotal bo The requestion of	enefits, with cred quirement for pay Rule1.1 requires BOARD'S REC WISTON MOLLISON WAY WISTON, ME 2466811	lit for earn ment of b filling of a	OFFICES  PORTLANI 62 ELM ST. PORTLAND 04101-3061	this subsection m of Payment.  D  D, ME
OTE: Reasons identified in boxes 19a or iditional issues at a later date.  IF THIS DENIAL NOTICE IS NOT TIME and the date of incapacity in accordance with 39 itomatically ceases upon the filing of a Note of the date of incapacity in accordance with 39 itomatically ceases upon the filing of a Note of the date of the d	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAIN R BANGOR, ME 0440\$638 (207)9414550	COMME  DN197 (Er  TO RULE 1.1 , the and in compliance with y and the payment of a discount of the payment of the pay	CURRENTDATE 20b.  DATE EMPLOYE  ENTS:  employee must be a 490 M.R.S.A. § 204 anyeddosenefits Paym  ERS' COMPENS. BOU HATCH DR&UBTE 180U, ME 36347 1498428 400-6855 PHONE #:	politotal bo The requestion of	enefits, with cred uirement for pay Rule1.1 requires  BOARD'S REC  WISTON  MOLLISON WAY WISTON, ME 2468811 17/93-7700 0-400-6857	iit for earr ment of b filing of a	OFFICES  PORTLANI 62 ELM ST. PORTLAND 04101-3061 (207)822084	this subsection m of Payment.  D  D, ME
ACTE: Reasons identified in boxes 19a or diditional issues at a later date.  1.  2. IF THIS DENIAL NOTICE IS NOT TIME of the control of the c	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAIN R BANGOR, ME 0440\$638 (207)9414550	DN197 (Er  TTO RULE 1.1 , the and in compliance with y and the payment of a life MAINE WORKE CARI CAR (207) 4800-4	employee must be a my M.R.S.A. § 204 employee my M.R.S.A. § 204 employee must be a my M.R.S.A. § 204 employee my	politotal bo The requestion of	enefits, with cred uirement for pay Rule1.1 requires  BOARD'S REC  WISTON  MOLLISON WAY WISTON, ME 2468811 17/93-7700 0-400-6857	lit for earr ment of b filing of a GIONAL	OFFICES PORTLANI 62 ELM ST. PORTLAND 04101-3061 (207)822084 1800-400-685	this subsection m of Payment.  D  D, ME
ASSISTANCE IS AVA  AUGUSTA 24 STONE SBUITE 2 AUGUSTA, ME 04336220 (207)282308 (Voice) 1-800400-6854 (Voice) TTY 1-877-8325525 3.NAME (TYPE OR PRINT):  DN140	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAIN R BANGOR, ME 0440\$638 (207)9414550	COMME  DN197 (Er  TO RULE 1.1 , the and in compliance with y and the payment of a discount of the payment of the pay	employee must be a 39 M.R.S.A. § 204 anyeddspnefits Paym HATCH DR8JETE IBOU. ME 38347 498428 400-6855 PHONE #: )	politotal bo The requestion of	enefits, with cred quirement for pay Rule 1.1 requires  BOARD'S REC WISTON MOLLISON WAY WISTON, ME 2468811 25. DAT	lit for earr ment of b filling of a GIONAL	OFFICES PORTLANI 62 ELM ST. PORTLANI 62 ELM ST. PORTLANI 62 ELM ST. PORTLANO 14101-3061 (207)822884 1800-400-685 TO WCB:	this subsection m of Payment.  D  D, ME  0  58
ASSISTANCE IS AVA  AUGUSTA 24 STONE SBUITE 2 AUGUSTA, ME 04336220 (207)282308 (Voice) 1-800-400-6854 (Voice) TTY 187-832-5525 3. NAME (TYPE OR PRINT):	MELY PURSUANT M.R.S.A.§ 205(2) a tice of Controversy MLABLE AT TH BANGOR 106 HOGAIN R BANGOR, ME 0440\$638 (207)9414550	COMME  DN197 (Er  TO RULE 1.1 , the and in compliance with y and the payment of a discount of the payment of the pay	employee must be a 39 M.R.S.A. § 204 anyeddspnefits Paym HATCH DR8JETE IBOU. ME 38347 498428 400-6855 PHONE #: )	politotal bo The requestion of	enefits, with cred quirement for pay Rule 1.1 requires  BOARD'S REC WISTON MOLLISON WAY WISTON, ME 2468811 25. DAT	lit for earr ment of b filling of a GIONAL	OFFICES PORTLANI 62 ELM ST. PORTLANI 62 ELM ST. PORTLANI 62 ELM ST. PORTLANO 14101-3061 (207)822884 1800-400-685 TO WCB:	this subsection m of Payment.  D  D, ME

NOTI	NT INCAPACITY CE OF CON' IS A DENIAL OF YOU IS A CROSSWALK to the IAL	OUR BENEFITS		ata el	ements )		1.	WCB FILE#	
(110te: the B1111tambers represent	t crosswant to the 171	EMPLOYEE	зе з прт и	utu Cr	ments.)				
2. EMPLOYEE LAST NAME:	<ol><li>FIRST NAME:</li></ol>		4. MI:	5. EMF	LOYEE ID:				
DN43	L	DN44	DN45	TVPF:	DN270	<sub>#</sub> .	N(42/1	152/153/1	54/156)
5. STREET/P.O. BOX MAILING ADDRESS:  NA - DN46  (will print all NA boxes wittelata from FRC	7. CITY: NA – DN	8. ST/ NA	TE: - DN49	9. ZIP		10. HO	ME PHOI	NE#: NA - 51	,
11. DATE OF INJURY: DN31/	12. SPECIFIC INJURY	OR ILLNESS: NA-DN35			13. BO	DY PAR		ECTED: DN36	
·		EMPLOYER							
4. INSURERCLAIM ADMINFILE #: DN15	EMPLOYER NAME: NA – DN18				S ADDRESS DN168, 16			and 159	
17. INSURERCLAIM ADMIN NAME AND ADDR $0.0000000000000000000000000000000000$	RESS: A-DN10, 12, 1	13, and 14			18. INSUREF	RCLAIM	ADMIN FI DN1		
19. YOUR EMPLOYER/INSURER IS DENY	YING YOUR WORKERS' C	NOTICE TO E MP	OR PART	OF IT.	THE REASON	N FOR T	HE DENI	AL IS CHEC	KED BELOW.
IF YOU DISAGREE WITH THIS  19a.	DENIAL, CONTACT A CLA	AIMS RESOLUTION SE 19b.	ECIALIST A	T THE	NEAREST R	EGIONA	L OFFICE	LISTED BE	LOW.
FULL DENIAL	REASON				PARTIAL D	ENIAL	REASC	N	
					D Values =	N294 A,B,E	F or G		
		20a.							
		DATE	- 1611	0457	NEW DA	I56 <sub>/</sub>			
			FINITIAL IN NTDATE OF			N144			
		20b.							
FULL DENIAL EFFECTIVE DATE /_ /	_				D DN	J281 <sup>,</sup>			
NOTE: Reasons identified in boxes 19a or 19b	- will not preclude a party fro	DATE E	MPLOYER N		DD	<b>√281</b> _/			
NOTE: Reasons identified in boxes 19a or 19b additional issues at a later date.	– will not preclude a party fro	DATE E			DDN	√281_ <u>/</u>			
"NOTE: Reasons identified in boxes 19a or 19b additional issues at a later date.  21.  22. IF THIS DENIAL NOTICES NOTTIME the date of incapacity in accordance with 3% M.I.	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp	DATE EI  COMMENTS:  DN197 (Enter narra  ULE 1, the employee r  oliance with 394 M.R.S.	ive)	OTIFIE	nefits, with cre	edit for e	arnings ar benefits	under this su	bsection
"NOTE: Reasons identified in boxes 19a or 19b additional issues at a later date.  21.  22. IF THIS DENIAL NOTICES NOTTIME the date of incapacity in accordance with 3% M.I.	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp of Controversy and the page	DATE EN DATE E	ive)  nust be pail to a 204. This its Payment u	OTIFIE OT	nefits, with crement for pa ule 1.1 requir	edit for exyment of es filing	arnings a benefits of a Mem	under this su orandum of F	bsection
AUGUSTA 24 STONE STSUITE 2 AUGUSTA, ME 043365220	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp of Controversy and the page	DATE EN DATE E	ive) nust be pail to 1. § 204. The itsPayments	otal bea e requi inder R BOA LEW 36 M LEW (207	nefits, with cre rement for pa ule 1.1 requir RD'S REGI	edit for exyment of es filing	amings at benefits of a Mem OFFICE POF 62 2 POF 041 (200	under this su orandum of F	bsection Payment.
NOTE: Reasons identified in boxes 19a or 19b additional issues at a later date.  21.  22. IF THIS DENIAL NOTICES NOTTIME the date of incapacity in accordance with 3% M. automatically ceases upon the filing of a Notice of ASSISTANCE IS AVAILA AUGUSTA.  24 STONE STSUITE 2 AUGUSTA, ME 043365220 (2077)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525 23. NAME (TYPE OR PRINT):	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp of Controversy and the pay ABLE AT THE MAINE T BANGOR 106 HOGAN ROAD BANGOR. ME 044015638 (207)941-4550	DATE EN DATE E	ive) nust be pail to 1. § 204. The itsPayments	otal bea e requi inder R BOA LEW 36 M LEW (207	hefits, with crement for pa ement for pa RD'S REGI STON OLLISON W. STON. ME 95811 1753-7700 400-6857	when the second	amings at benefits of a Mem OFFICE POF 62 2 POF 041 (200	under this su orandum of F S RTLAND ELM ST. RTLAND, ME 01-3061 '01-3061 '01-3064 '01-400-6858	bsection Payment.
22. IF THIS DENIAL NOTICES NOTTIME the date of incapacity in accordance with 39 M.I. automatically ceases upon the filling of a Notice  ASSISTANCE IS AVAILA  AUGUSTA 24 STONE ST SUITE 2 AUGUSTA, ME 4336520 (207)2872308 (Voice) 1-800-400-8854 (Voice) TTY 1-877-832-5525	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp of Controversy and the pay ABLE AT THE MAINE T BANGOR 106 HOGAN ROAD BANGOR. ME 044015638 (207)941-4550	DATE Efform raising  COMMENTS:  DN197 (Enter narra  ULE 1, the employee r  Diliance with 394 M.R.S.  Interpretation of any accrued bene  WORKERS' COMPI  CARIBOU  43 HATCH DRI CARIBOU. ME  0473-2347  (207149804281  800-400-6855	ive) nust be pail to 1. § 204. The itsPayments	otal bea e requi inder R BOA LEW 36 M LEW (207	hefits, with crement for pa ement for pa RD'S REGI STON OLLISON W. STON. ME 95811 1753-7700 400-6857	when the second	amings a benefits of a Mem OFFICE POF 041 (207 1-800	under this su orandum of F S RTLAND ELM ST. RTLAND, ME 01-3061 7)8220840 0-400-6858	bsection Payment.
**NOTE: Reasons identified in boxes 19a or 19b additional issues at a later date.  21.  22. IF THIS DENIAL NOTICES NOTTIME the date of incapacity in accordance with 3% M.I automatically ceases upon the filling of a Notice of ASSISTANCE IS AVAILA AUGUSTA.  24 STONE STSUITE 2 AUGUSTA, ME 043365220 (207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525 23. NAME (TYPE OR PRINT):	ELY PURSUANT TO RI R.S.A. § 205(2) and in comp of Controversy and the pay ABLE AT THE MAINE T BANGOR 106 HOGAN ROAD BANGOR. ME 044015638 (207)941-4550	DATE Efform raising  COMMENTS:  DN197 (Enter narra  ULE 1, the employee r  Diliance with 394 M.R.S.  Interpretation of any accrued bene  WORKERS' COMPI  CARIBOU  43 HATCH DRI CARIBOU. ME  0473-2347  (207149804281  800-400-6855	ive)  nust be pail to 1, \$ 204. Thi tisPayment ENSATION	otal bea e requi inder R BOA LEW 36 M LEW (207	nefits, with crement for pa ule 1.1 requir RD'S REGI STON OLLISON W/ STON. ME 96811 400-6857	edit for expensed of the second of the secon	arnings at benefits of a Mem  OFFICE  PO 62 1 POF 1800  NT TO W  ON1	under this su orandum of F S RTLAND ELM ST. RTLAND, ME 01-3061 7)8220840 0-400-6858	bsection Payment.

### **APPENDIX D:** FROI CROSSWALK

#### EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

DN5	
1a. OSHA 300 CASE NUMBER applicable):	(if

1. WCB FILE NUMBER (if

(Note: the DN Numbers rep	resent a crosswalk to t	he IAIA	ABC Clai	ims	Release 3 ED	)I da	ta elements.)		applicable):		
	REASON	FOR RE	PORT (ch	neck	all that apply)				TVA		
2a. ☐ LOST TIME - ONE OR MORE DAYS DN7 3. ☐ LOST EARNINGS BUT NO LOST TIME NA	4 2b. WAS EMPLOYEE PAID F 4. MEDICAL/HEALTH C	OR ½ DA	Y OR MORE		DAY OF INJURY?	LITY I	DATE OF DEATH:	//	<del></del>		
6a. ☐ OCCUPATIONAL DISEASE DN290	6b. DATE OF LAST EXPOSU	JRE:									
YYYY 7a. □ CORRECT PRIOR REPORT DN2	7b. DATE OF CORRECTION				N3 7c. DATE CO	ORREC					
Note: also see correction process 8	DN295. 296	MM[	DD YYYY					MM DD Y	YYY		
8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): DN329	9. FEDERAL EMPLOYER ID	ENTIFICA	ATION NUME	BER (	FEIN): DN16		10. EMPLOYER NAI	ME: DN18			
11. STREET/P.O BOX MAILING ADDRESS: DN168-169	12. CITY: <b>DN165</b>			13. 9	STATE: DN170		14. ZIP: <b>DN167</b>	15. TELEPH	HONE NUMBER: DN159		
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: DN25	MAILING ADDRESS: DN19-23	DN19-23 EMPLOYER PHYSICAL COUNTRY				18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES I DN24  IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE EMPLOYEE WAS INJURED OR EXPOSED: DN120; 119, 122, 121, 123, 33, ACCIDENT SITE COUNTRY CODE = DN280					
(check one) INSURER	☐ THIRD	PARTY	ADMINIST	TRA	TOR (TPA)			SELF-ADMI	NISTERED EMPLOYER		
19. INSURANCE / TPA COMPANY NAME: DN7/188	20. POLICY NUMBER: DN28					2	1. INSURER FILE NUME	BER: DN15			
22. STREET/P.O. BOX MAILING ADDRESS: DN10-11	23. CITY: <b>DN12</b>			24. \$	STATE: DN13	2	5. ZIP: <b>DN14</b>	26. TELEPH	HONE NUMBER: ) NA		
27. LAST NAME: <b>DN43 &amp; DN255</b>	28. FIRST NAME: DN44		29. MI: DN45				1. SOCIAL SECURITY N DN42	IUMBER:	32. GENDER: <b>DN53</b> ☐ MALE ☐ FEMALE		
33. STREET/P.O. BOX MAILING ADDRESS: DN46-47	34. CITY: <b>DN48</b>				35. STATE: <b>DN49</b>	3	6. ZIP: <b>DN50</b>	,	TE OF BIRTH: <b>DN52</b>		
38. OCCUPATION/JOB TITLE: DN60	39. DATE OF HIRE: DN61  MM DD YYYY		40. WEEKLY WAGE AT TIME OF INJURY:  \$ DN62				41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER?  YES NO IF YES, GIVE NAME AND ADDRESS:				
	DATE OF INCAPACITY:  _//DN56		ME EMPLOY 7:30 a.m.):	EE B	EGAN WORK		5. DATE EMPLOYER NO		RER/TPA OF INJURY:		
	I DD YYYY TE EMPLOYER NOTIFIED:		46. TIME OF INJURY (e.g. 1:10 p.m.): 47. HAS EMPLOYI					EE RETURNED TO WORK? YES NO DN189			
	//_DN281		IF YES, GIVE DATE						:DN68		
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):  DN35	49. BODY PART(s) AFFECTED (c	e.g. lower	right forearm	):		USING			EMICALS EMPLOYEE WAS g. acetylene torch, metal plate):		
51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGE OCCURRED (e.g. cutting metal plate for flooring.):	51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.):				52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS O SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): DN38						
NA				.,				,			
□ YES □ NO NA	WAS THE EMPLOYEE TREATESS. HE/AN EMERGENCY ROOM?  YES NO: NA NA		PROVICER N	NAME:	56. MAILIN	G ADI	DRESS:	57. TE	ELEPHONE NUMBER: ) <mark>NA</mark>		
58. PREPARER NAME AND TITLE (TYPE OR PRINT): NA		59. TE	LEPHONE N ) <mark>NA</mark>	NUMB	ER:			60. DATE SE	ENT TO WCB: <b>DN100</b>		
The State of Maine provides equal opprequest. For assistance with this form, Relay 711.  WCB-1 (eff. 1/1/13)								to individu	als with disabilities upon		